Harm Reduction Treatment for Alcohol

HaRT-A Manual

Susan E. Collins
Seema L. Clifasefi
Lonnie A. Nelson
Cat Cunningham

at the University of Washington

In collaboration with the 1811 Eastlake Resident Advisors and Community Advisory Board

Introduction

This manual outlines the style and components that comprise the Harm Reduction Treatment for Alcohol (HaRT-A) for people with the lived experience of homelessness and alcohol use disorders (AUDs). The HaRT-A is designed to build rapport between the study interventionists and participants and to guide alcohol-specific harm reduction counseling. The ultimate aim of the HaRT-A is to support participants' own steps towards alcohol harm reduction and quality-of-life enhancement.

The HaRT-A was designed based on a) the research team's prior work on harm reduction theory;[1-3] b) prior research and clinical experience with harm reduction interventions and treatment for alcohol (e.g., UW-DESC Bridge Study, the Life Enhancing Alcohol-management Program [LEAP], Project Vivitrol, and Harm Reduction with Pharmacotherapy [HaRP]);[4-11] c) over 50 interviews with people with the lived experience of AUDs and homelessness; d) 8 focus groups with staff and management working with homeless people with AUDs; e) the input of a community advisory board comprising individuals with the lived experience of homelessness and AUDs as well as staff and management working in a community-based agency serving homeless people with AUDs; and f) the collaboration of volunteers with the lived experience of homelessness and AUDs who participated in a pilot study of the HaRT-A and provided *in vivo* and comprehensive feedback for treatment development and refinement.

Rationale for the HaRT-A

AUDs among homeless individuals represent a serious public health issue. A meta-analysis of international studies showed a mean of 38% of homeless individuals are affected by AUDs.[12] AUDs interfere with tasks of daily living, such as attaining and maintaining housing, employment and social networks.[13-15] The more severe AUDs that often affect homeless individuals are associated with both acute (e.g., accidents, falls, violence) and chronic (e.g., chronic liver disease, cancer, cardiovascular disease, encephalopathies) alcohol-related harm.[13,16] These problems place increased burden on the health-care and criminal justice systems,[17] and put individuals at greater risk for alcohol-related mortality.[18-20] Considering the extent and cost of negative consequences for both affected individuals and their communities, effective approaches are needed to engage and address the issues facing homeless people with AUDs.

Current abstinence-based programs do not optimally engage and treat this population. Alcohol abstinence has long been assumed to be the *sine qua non* of effective treatment, particularly for more severely affected and homeless populations. However, findings have been mixed for abstinence-based treatments among homeless individuals, ranging from no to modest improvements on substance-use outcomes.[15,21,22] Further, these improvements are only experienced by the few who are engaged and retained in treatment.[15] In fact, studies show that few homeless people start treatment (15-28%),[23,24] and even fewer complete it (2.5-33%).[25] A review conducted by the US National Institute on Alcohol Abuse and Alcoholism showed that treatment engagement in this population decreased as program demands—particularly abstinence—increased.[25] The end result is that the majority of homeless individuals with AUDs never go to, are turned away from, or drop out of the treatments that are currently available.

Recent research has elucidated reasons why abstinence-based treatment is not optimally engaging and effectively treating this population. First, our own and other research groups' studies show that many of the most severely affected individuals do not find abstinence-based goals or treatments to be acceptable or desirable.[6,26] Such negative evaluations of abstinence-based treatment are correlated with decreased treatment attendance[27] and poorer outcomes.[28] Thus, even if these individuals do present for treatment, they are less likely to stay in treatment and achieve positive effects. Relatedly, both theory and empirical data suggest that repeated failed treatment attempts erode self-efficacy and self-control for later behavior change.[29,30] This observation is particularly relevant for this population: one of our recent studies showed a mean of 16 past alcohol treatment attempts in a sample of homeless individuals with AUDs.[31] Additionally, inpatient detoxification, typically a medical necessity for this population, is expensive and can lead to a "revolving door" of treatment,[32,33] in which abstinence-based treatment episodes are regularly alternated with resumed use. The revolving door effect is a concern in this population because an increasing number of alcohol withdrawals and medical detoxifications can precipitate increasingly severe and potentially fatal alcohol withdrawal

symptoms (i.e., kindling effect),[34] which may make abstinence-based treatment a more harmful course of action for some more severely affected individuals.

Harm-reduction service and housing interventions appear to engage and address this population's needs. New, low-barrier approaches have recently begun to be applied with homeless individuals with AUDs.[13,35] Such approaches have been referred to as harm-reduction interventions because they focus on supporting client-driven means of reducing alcohol-related harm for individuals and their communities without requiring abstinence-based treatment goals.[1] Such interventions, including alcohol management programs and low-barrier housing programs,[13,31,36] have shown preliminary effectiveness in reducing both alcohol-related harm and alcohol use.[37,38] Whereas these service-oriented harm-reduction approaches are beginning to proliferate for this population, there are few psychosocial intervention counterparts to further support these positive effects. In response, we are introducing the HaRT-A to support and enhance the effects of service and housing harm-reduction interventions.

HaRT-A Manual

The HaRT-A was designed to engage and address the needs of individuals with the lived experience of homelessness and AUDs for whom traditional, abstinence-based treatment has not shown long-term effectiveness. The HaRT-A manual is compatible with and complementary to existing harm-reduction oriented supportive services. HaRT-A components will be delivered by study interventionists with prior training in the principles of harm reduction and motivational interviewing.

HaRT-A was inspired by harm reduction theory (S E Collins et al., 2011; Marlatt, 1996) and practice (S E Collins, Duncan, et al., 2015; S E Collins et al., 2014; Denning & Little, 2012); by patient-centered clinical practices (e.g., motivational interviewing (W. R. Miller & Rollnick, 2012), humanistic psychotherapy (Rogers, 1957)); and by a decade of our team's qualitative and quantitative research on the needs and preferred treatment pathways of marginalized communities affected by AUD (S E Collins, Clifasefi, Dana, et al., 2012; S E Collins, Duncan, et al., 2015; S E Collins, Grazioli, et al., 2015; S. E. Collins et al., 2016; S E Collins et al., 2014; V. Grazioli et al., 2015; V. S. Grazioli, Collins, Daeppen, & Larimer, 2014). The specific HaRT-A mindset, heart-set, and components were developed by a team comprising researchers, marginalized individuals with AUD, and providers serving these individuals using an iterative, community-based participatory research process (S E Collins et al., in press). The conceptual model is shown in Figure 1.

The **HaRT-A mindset** stems from the overarching harm-reduction philosophy. It supports the realization of participant-driven goals and recognizes any participant-led movement toward reducing harm and improving HR-QoL as positive steps on a participant-defined pathway to recovery (Marlatt, 1998). (It is important to note that "recovery" in harm reduction does not imply abstinence or compliance with interventionists' conceptualization of recovery.) HaRT-A interventionists are transparent about their agenda: The overarching aim of HaRT-A is to help drinkers and their communities reduce alcohol-related harm and improve QoL. It is, however, also emphasized that these aims are broadly conceived, so that participants define their own recovery pathway. Participants may invite interventionists to walk with them on that pathway and leverage their knowledge (i.e., information about safer use) to empower participants to make their own informed decisions about their alcohol use moving forward.

The **HaRT-A heart-set** entails a *compassionate way of being* with a participant. In this case, compassion refers to "feeling with" the participant coupled with an unconflicted desire to support participant-defined and -led treatment goals. This compassionate way of being is conveyed through means that will be familiar to those who practice motivational interviewing: *openness to, acceptance of, and fundamental respect for the shared humanity* with the "other" and the other's values, beliefs, concerns and priorities (W. R. Miller & Rollnick, 2012). HaRT-A then builds further upon these patient-centered values by supporting participants in setting, striving toward, and achieving exclusively participant-led goals, providing the opportunity for *transformative change* through intrinsic rather than extrinsic motivation. HaRT-A interventionists balance this support with *complete transparency* regarding their role in the system and its limitations (e.g., research on treatment is not and cannot substitute for case management and ongoing clinical service provision) and the harm-reduction agenda (i.e., alcohol harm reduction and QoL improvement). HaRT-A entails *matter-of-fact pragmatism*: interventionists allow creativity and flexibility in their approach to maximize their alignment

with participants' harm-reduction goals. Finally, HaRT-A interventionists engage in *advocacy for participants.* For example, in this study interventionists facilitated participants' connections to needed and desired services. The mindset and heart-set are conveyed to participants at the beginning of HaRT-A, and throughout the sessions to remain transparent about the interventionists' role and to remind participants of the rationale for the treatment they are cocreating with interventionists.

The **HaRT-A components** are delivered in the context of the mindset and heart-set and include a) collaborative, participant-led tracking of alcohol outcomes, b) elicitation of participants' harm-reduction and QoL goals, and c) discussion of safer drinking strategies.

For the first component, interventionists provide personalized feedback on participants' self-reported harm-reduction outcomes (e.g., score on the SIP-2R to reflect changes in participants' level of alcohol-related harm). Interventionists focus in particular on outcomes that have improved, providing affirmations. In the case of flat trajectories or increasing alcohol-related harm, interventionists provide affirmation for other positive behaviors supporting their goals (e.g., attendance at HaRT-A sessions) as well as encouragement for participants' continued efforts. Next, interventionists encourage participants to select one or more outcomes they wish to track over the duration of the study. Interventionists help participants create a paper-and-pencil graphic representation of their progress, which is updated at each session.

For the second component, interventionists elicit participants' harm-reduction and QoL goals and assess progress made toward them. Of note, goals are not required to be focused on substance use and are not to be shaped by the interventionist. Goals might involve a focus on reducing alcohol-related harm. For example, some participants might be interested in reducing their experience of heavy-drinking episodes, use of nonbeverage alcohol (e.g., hand sanitizer), or blackouts. Other participants might choose to focus on achieving QoL-related goals, such as engaging in a hobby, starting a fitness program, or reconnecting with meaningful relationships. Interventionists record participants' weekly harm-reduction goals and collaboratively assess at subsequent sessions whether participants have fully, partially or not achieved their stated goals. Interventionists use a sense of curiosity and wonder by way of open-ended questions and strengths-based reflections to elicit participants' stories about their progress toward their harm-reduction goals and provide affirmations and encouragement to support ongoing goal actualization. Regardless of participants' progress toward their goals, interventionists remain supportive and accepting of participants and offer affirmations for efforts, even if goals are not achieved. Interventionists also help participants break down goals into smaller, more achievable step-wise goals, and engage in trouble-shooting to help remove barriers to their realization.

The third component entails discussion of the relative risks and benefits of participants' current drinking and strategies that can help them a) stay healthier when drinking (e.g., drinking water to stay hydrated, taking B-complex vitamins to avoid thiamine deficiency), b) alter the manner in which they drink (e.g., drinking in a safe place, not mixing drugs and alcohol), or c) change the amount they drink (e.g., drinking reduction, abstinence). If reduction or abstinence is a goal, and a participant is physically dependent, interventionists review information on the risks of alcohol withdrawal as well as tapering schedules (Anderson, 2010) or the possibility of a medically supervised withdrawal if a participant prioritizes an abstinence-based goal. This discussion is facilitated by a safer drinking handout (see Figure 2) that gives participants information they need to make more scientifically informed decisions about their use.

Baseline Session: Assessment/HaRT-A

The key components of the baseline session as conducted by the study interventionists include:

- Opening the session (5 min)
- Reviewing drinking assessment (5 min)
- Establishing participant-driven goals (10 min)
- Introducing safer drinking tips (10 min)
- Wrapping up (5 min)

> ***Note:*** When participants arrive it is important to turn on your "emotional radar." In our studies, we have observed that participants are often sensitive to what they perceive in the person across from them. In essence, we have found that these participants—as all of us—tend to give back what they are given. It is therefore important to show respect, warmth and model (not intrusively impose) well-placed boundaries from the first intervention contact. What is typically considered to be a "nonspecific treatment effect" often serves as a powerful intervention and sets the tone for a positive interaction.

Opening the Session

Greet participants, offer them light refreshments (e.g., coffee, water or juice), and thank them for taking the time to talk to you. Briefly review the study timeline so participants have clear expectations about upcoming visits, what is being asked of them and their compensation schedule. Discuss the agenda for the baseline session specifically, and elicit and respond to participants' questions. After you are done with this introduction, ask if it's ok to turn on the recorder for the rest of the session. Let participants know this is primarily for quality control of your work as an interventionist.

Review Drinking Assessment

Next, review participants' alcohol assessment based on the questionnaires completed in the assessment meeting. It is important to be nonjudgmental and to focus on specific examples and numbers they reported.

> *Looking at the questions you answered before with [assessment person], it appears you are currently drinking on xx days a month. On a typical day, you said you drink xx drinks. On your heaviest day in the past month, you said you drank xx.*
>
> Wait for participants' response to be sure you are correct in your summary.
>
> *You also said you have been experiencing some negative side effects, such as…* [Fill in specific examples from the Short Inventory of Problems]

In the packets, you will find blank grids (see Attachment A) on which you can help participants record the drinking outcomes of their choice (y-axis) and track their progress over time (x-axis). The outcomes they chose to track and the tracking itself should be left to the participant to decide. You might say:

> *Some people find it helpful to track their alcohol [use, consequences] over time so they can see how these things change. Which of these would you like to track over time?*

It is also important to tie this feedback into the rationale for the study and the components of the session. You might say:

> *One of the things we can talk about in these meetings is how to reduce these side effects of alcohol that bother you and help you drink safer. Also, we will be talking about what kinds of things you would like to see happen for yourself in your life and how to work towards these goals/intentions/hopes/dreams. I will not be asking you to change your drinking in any way that you don't want to.*
>
> *How does that sound?*

Establishing Participant-driven Goals

Some participants have goals in mind when they talk to a treatment professional. Others may have given this topic less thought. Still others are convinced that ***you*** believe the only legitimate goal is abstinence and might feel compelled to say what they think you would like to hear. This is why it is important to use simple, open-ended questions to elicit treatment goals that participants believe are reachable and desirable. These treatment goals should be viewed as the most important therapeutic outcomes for the treatment (regardless of the research hypotheses). **Again, the most important job you have is to understand what the participant thinks is important and support this. Make this a fluid conversation in which you get to know the goals that are closest to your participant's heart. Have them tell you stories about what they want to see happen for themselves and why and reinforce these goals.**

You may elicit these goals by asking:

- *We will be meeting over the next few weeks. What kinds of things would you like to see happen for yourself?*
- *Some people call this a goal.* (Write these down under "Participant's Goals" on the SHaRE form in Attachment B.)
- *What else?/What other goals are you interested in achieving for yourself?*
- *Do you foresee any barriers to achieving these goals?*
- *What can I do to help you work towards that goal?*

Note: the client does NOT need to mention alcohol or other drug use reduction or abstinence goals.

If the client mentions more than one goal, ask them to rank them in the order of importance to them.

The word "goal" may not resonate with all participants. Pay attention to the words they use and use those instead (e.g., intentions, hopes, dreams).

In our initial studies, participants have said that experiencing successes with goals that are affirmed and praised by interventionists is very important. Thus, **we want individuals' goals—particularly those in the earlier sessions—do be achievable within the next week to ensure this process builds participants' self-efficacy about goal-setting and achievement.**

So, if participants mention larger goals that may be difficult to achieve right away (e.g., "reconnecting with my son"), help them to break these goals down into more achievable pieces. You might say,

"That's a great goal [affirmation]! It's also a big goal. What do you think is the first step in achieving that goal?"

You may then help participants visualize the stepwise nature of goal-setting using the visual aid in Attachment C. You might record a larger goal (e.g., reconnecting with son) in the top step, and going back down to the bottom step and asking the participant to name the first step towards that larger goal. This could be used from week to week to make incremental progress towards a larger goal.

Goals must be recorded on the SHaRE. As you write down goals in on the SHaRE form, help participants copy the same onto the handout to take with them (see Attachment B).

Note: Goals must be of a nature AND number that is achievable by the next session. So, even if participants are enthusiastic, help them break larger goals down and ensure the number is manageable. Be sure to provide affirmation and praise when participants reach goals. The most important intent of setting and achieving goals in the HaRT-A is to build participants' self-efficacy about the process.

Introducing Safer Drinking Tips

Interventionists should now introduce the safer drinking tips (see Attachment B) and engage participants in a discussion of the safer drinking tips that they may try out over the next few weeks. Even if participants are not interested in reducing drinking or achieving abstinence, there are still things they can do to decrease the risks and harm they experience due to alcohol use. To introduce this discussion, you might say:

> *We have been talking about your goals/things you would like to see happen for yourself in the next week. One thing you mentioned is reducing negative side effects [or one thing that some people find helpful is also reducing negative side effects from drinking].*

Show the Safer Drinking Tips (see Attachment B) to participants and:

- If they have already mentioned wanting to reduce their drinking/drink safer as one of their goals, this can be pointed out on the list, and this goal can be reinforced as a step towards safer drinking.
- Introduce the three main categories of safer drinking tips, providing one or two examples for each category.
- Inquire if they have ever tried any of the things on the list to reduce the harm they experience while drinking (*"These are some tips that you can use to drink more safely. Have you ever tried doing anything on this list before?"*)
- If so, ask participants: *"How did that go?"* or *"What was that like for you?"*
- Support participants' self-efficacy by reinforcing these efforts (e.g., *"It's great that you have been able to keep from drinking while you sell your Real Change papers. What made you decide to do that? How were you able to do that?"*)
- Ask if they would be interested in choosing a safer drinking tip to try out over the next week. Check or circle these for participants. Participants can also add their own tips on the blank lines. Also, note these on the SHaRE under "Participant's Safer Drinking Plan."
- As participants choose their safer drinking tip(s), interventionists should casually mention why that is a safer choice based on what we have covered in the interventionist training (see Attachment D). For example, *"Avoiding mixing crack and alcohol is a healthier decision because crack revs your heart up while alcohol slows it down. That means your body has two forces fighting each other which puts a strain on your heart."* Or, "*Taking vitamins like B12, folate and thiamine can help protect your brain from damage when you drink. You can ask your provider or case manager how to get those. We especially recommend prenatal vitamins."*
- Inform participants you will check in with them during the next meeting about their safer drinking plan to see how it worked out for them.
- Participants should receive the safer drinking tips handout (with their harm reduction goals on the back) to take with them (see Attachment B).

Wrapping up

Thank participants for their time and willingness to talk to you. Let participants know that you value their feedback about the session and that you would like to ask them how they felt it went and what you could do to improve the usefulness of these meetings. (Note these for our staffing meetings so we can keep participant satisfaction on our radar.) Be sure they have their copy of the safer drinking tips/goals. Schedule participants for their next follow-up assessment appointment. Update your tracking information for them. Compensate them $20 for their time, and have them sign the payment receipt. Ask them if they have any further questions.

Follow-up Sessions - Weeks 2 and 3 and 1-month Follow-up

The key components of follow-up sessions include:

- Opening the session (2 min)
- Reviewing alcohol assessment (5 min)
- Checking in about goals established in the prior session/establishing next set of goals (10 min)
- Checking in about safer drinking plan established in the prior session/establishing new plan (10 min)
- Wrapping up (5 min)

Prior to this session, review participants' alcohol assessment, previously stated goals, safer drinking plans, concerns and/or questions to prepare for the session.

Opening the Session

Greet participants, offer them light refreshments, and thank them for taking the time to talk to you. Briefly review the study timeline so participants have clear expectations about upcoming visits, what is being asked of them and their compensation schedule. Discuss the agenda for the baseline session specifically, and elicit and respond to participants' questions. After you are done with this introduction, ask if it's ok to turn on the recorder for the rest of the session.

Reviewing alcohol assessment

Next, review participants' alcohol assessment based on their responses to the questionnaires. It is important to be nonjudgmental and to focus on specific examples and numbers they reported.

> *Looking at your responses, you are currently drinking on xx days a month. On a typical day, you said you drink xx drinks. On your heaviest day in the past month, you said you drank xx.*
>
> Wait for participants' response to be sure you are correct in your summary.
>
> *You also said you have been experiencing some negative side effects, such as…* [Fill in specific examples from the Short Inventory of Problems]

Ask people if they would like to look at their tracking form to see how this fits in to the larger picture. If people's alcohol use and/or side effects have decreased, be sure they note that on the chart. Elicit a story from the participant about how they were able to make those changes, how that went and how they feel about it. This is affirming in and of itself, but also be sure to provide affirmation for the positive steps they are taking towards being safer and healthier.

If individuals wanted to make changes but were unable to, affirm them for having come to the session—that is a really huge step towards making a change--and working towards other goals in the next section. Affirm them for other things that they have been doing positively, and introduce the next section.

Participant-driven goals

Ask participants about their progress towards their goals. For example,

> *"Last time we discussed your goals. You told me you were interested in feeling more in control of your drinking. I wanted to check in and see how that has been going for you?"*

Using open-ended questions and prompts, allow participants tell you about their experiences—**focus on eliciting a story and NOT simply asking about whether they achieved the goal or not**. Additionally**, verbally reinforce any**

positive steps they have taken towards achieving their goals. Record participants' progress towards or achieved goals in the appropriate place on the SHaRE form section for the previous visit, and add comments as necessary.

Next, using the dialogue suggested in Week 1, elicit and support additional goals for focus in the next week/month. Record these on both participants' new handout and on the SHaRE form.

Safer Drinking Tips

Check in about participants' safer drinking plans they had committed to during the previous meeting. You can prompt them by saying,

> *"Last time you told me you wanted to try to stick to six regular beers instead of drinking four 211s each day. How did that go?"*

Again, be sure to elicit a story versus simply checking off whether they had achieved or not achieved the safer drinking step.

Record achievement of safer drinking goals on the SHaRE form for the previous visit. Then, refer participants to the Safer Drinking Tips worksheet, and ask participants what safer drinking tips they would be interested in trying until the next session using the suggested prompts provided in baseline session. Circle or check these so participants can see which ones they endorsed. These should also be recorded on the SHaRE under "Participant's safer drinking plan."

General notes on safer drinking/goals assessments

If participants report having achieved their goals/safer drinking plans, be sure to reinforce that:

> *"Congratulations on making this commitment and sticking to it! What was that like sticking to your goal/safer drinking plan this month?"* [or "*What differences did you notice?*"]

If participants report not having achieved their goals/safer drinking plan, be sure to encourage them to try again using nonjudgmental and supportive language. You should be sure to convey warmth and unconditional positive regard towards participants regardless of their response. You might say:

> *"Change can occur in small steps. Even committing to this goal/safer drinking plan is another step towards reducing your harm. What do you think about trying towards this goal/safer drinking plan again for this next month?"*

To elicit barriers, you might say:

> *"Ok, you tried [xx] over the past week, and it didn't work out quite the way you wanted it to. Why do you think that might be?/What could you do differently this week to try again?"*

You can also ask participants:

> *"On a scale from 0 to 10, where 0 is not at all important and 10 is very important, how important is this goal/safer drinking plan to you?"*
>
> *"On a scale from 0 to 10, how confident are you that you can achieve this goal/safer drinking plan?"*

If this is a lower number, ask participants, "*What would it take for you to move from a 3 to a 6?*" And help them problem solve around this. "*What can I do to help you achieve this goal/safer drinking*

plan?" If they are no longer interested in that goal/safer drinking plan, elicit new strategies that resonate more with them where they are currently at.

Regardless of participants' outcomes, you should take this opportunity to provide affirmation for coming to the meeting:

> *"The fact that you came in today shows your commitment to working towards your goals and safer drinking. That's great!"*

Ask participants about any other efforts they have been making since you last saw them—maybe working with their case manager on this or going to support groups. Be sure to reinforce those other, related efforts as well.

Wrapping up

Thank participants for their time and willingness to talk to you. Let participants know that you value their feedback about the session and that you would like to ask them how they felt it went and what you could do to improve the usefulness of these meetings. (Note these for discussion in our staffing meetings.) Be sure they have their copy of the safer drinking steps/goals. Schedule participants for their next follow-up appointment. Update your tracking information for them. Compensate them $20 for their time, and have them sign the payment receipt. Ask them if they have any further questions.

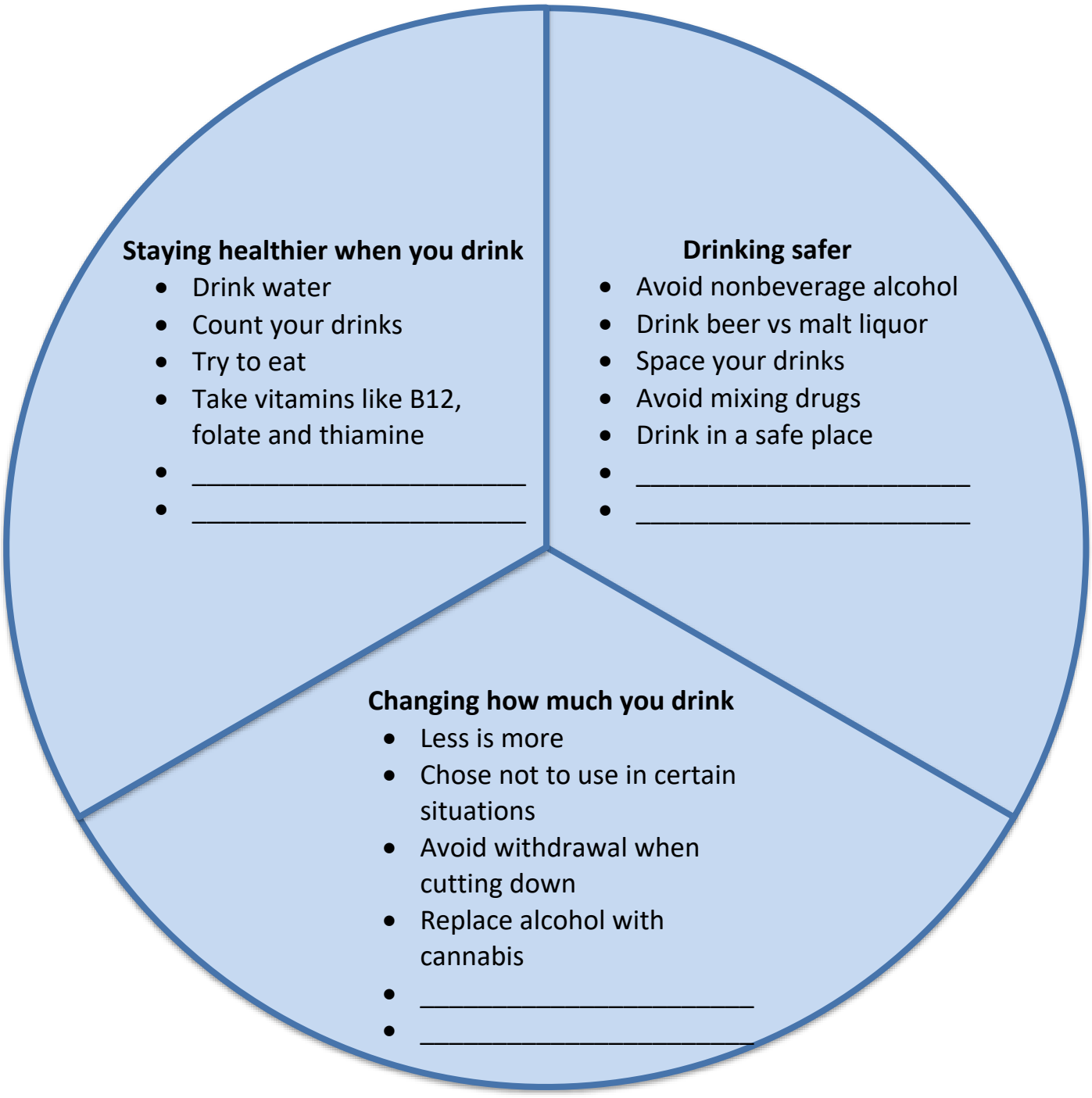
Attachments

Attachment A

Attachment B. Safer drinking tips/goals

Safer Drinking Tips

Here are some tips you can use to stay safer and healthier no matter how you choose to change your drinking. Please select at least one thing on the list you would like to try over the next week. We can talk about how these steps can help you reduce the "not-so-good things" about your drinking, and check in about how it went at our next meeting.



What I want to make happen for myself

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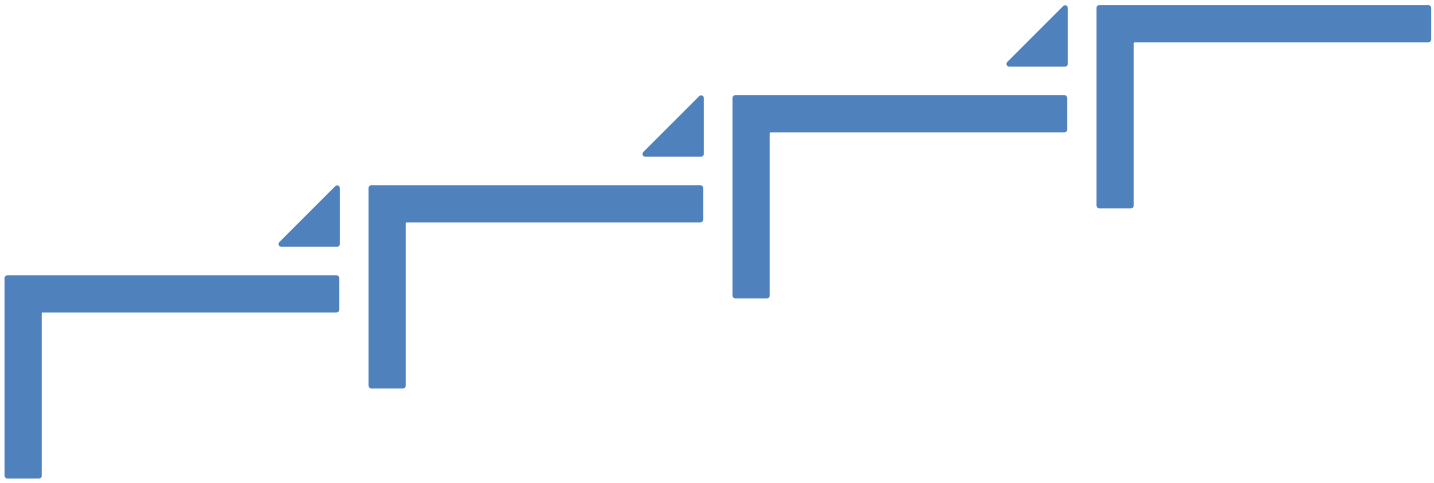
Attachment C



Attachment D

Safer Drinking Steps

Here are some tips to keep you safer and healthier no matter how you choose to change your drinking. Please select at least one thing on the list you would like to try over the next week. We can talk about how these different steps may reduce "not-so-good things" about your drinking, and we will check in about how it went at our next meeting.

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